# Premier Family Eyecare
## Medical History

Todays Date: _____

**Patient Name:** _____ **Date of Birth:** _____

Are you allergic to any medications? N Y If yes, please list medications: _____

Please list any current medications (with dosage) you are taking (including over-the-counter eye drops, vitamins or supplements, aspirin and oral contraceptives). _____

List any major injuries, surgeries and/or hospitalizations you have had and date(s).

**Your Eye Symptoms** – Do you (patient) experience any of the following? Please circle No or Yes.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Blurred Vision | N Y | Flashing Lights | N Y | Seeing Rings Around Lights | N Y | Dry Eyes | N Y |
| Distorted Vision | N Y | Painful Eyes | N Y | Color Vision Difficulties | N Y | Floating Spots | N Y |
| Double Vision | N Y | Gritty/Sandy Eyes | N Y | Depth Perception Problem | N Y | Burning Eyes | N Y |
| Red Eyes | N Y | Aching Eyes | N Y | Losing Place While Reading | N Y | Excessive Squinting | N Y |
| Watery Eyes | N Y | Drawing/Pulling | N Y | Night Vision Problems | N Y | Discharge From Eyes | N Y |
| Itchy Eyes | N Y | Dizziness | N Y | Extreme Light Sensitivity | N Y | | |

**Do you or have you ever experienced any problems in the following areas? Please circle No or Yes.**

**Allergy/Immunological**

| | |
|---|---|
| Drug Allergy | N Y |
| Environmental Allergy | N Y |
| Rheumatoid Arthritis | N Y |
| Lupus | N Y |
| Osteoarthritis | N Y |

**Gastrointestinal**

| | |
|---|---|
| Crohn's | N Y |
| Colitis | N Y |
| Ulcer | N Y |
| Digestive | N Y |

**Psychiatric**

| | |
|---|---|
| Depression | N Y |
| Panic Disorder | N Y |
| Schizophrenia | N Y |

**Endocrine**

| | |
|---|---|
| Non-insulin Dependent Diabetes | N Y |
| Insulin Dependent Diabetes | N Y |
| Thyroid Dysfunction | N Y |
| Hormonal Dysfunction | N Y |
| LBS: | |
| HbgA1C: | |

**Eyes**

| | |
|---|---|
| Glaucoma | N Y |
| Cataracts | N Y |
| Macular Degeneration | N Y |
| Eye Surgery | N Y |
| Inflammatory disorder | N Y |
| Blurred vision | N Y |
| Double Vision | N Y |

**Neurological**

| | |
|---|---|
| Multiple Sclerosis | N Y |
| Epilepsy | N Y |
| Alzheimer's | N Y |
| Parkinson's | N Y |
| Cerebrovascular | N Y |
| Migraines | N Y |
| Seizures | N Y |

**Ear/Nose/Throat**

| | |
|---|---|
| Upper Resp Track Infection | N Y |
| Ear ache | N Y |
| Runny nose | N Y |
| Sore throat | N Y |
| Ringing/tinnitus | N Y |
| Sinus Congestion | N Y |

**Musculoskeletal**

| | |
|---|---|
| Fibromyalgia | N Y |
| Muscular Dystrophy | N Y |
| Ankylosing/Spondylitis | N Y |

**Constitutional**

| | |
|---|---|
| Developmental Disability | N Y |
| Weight loss | N Y |
| Fever | N Y |
| Fatigue | N Y |
| Trauma | N Y |

**Lymphatic/Hematological**

| | |
|---|---|
| Anemia | N Y |
| Large volume blood loss | N Y |
| Leukemia | N Y |

**Integumentary**

| | |
|---|---|
| Eczema | N Y |
| Rosacea | N Y |
| Psoriasis | N Y |
| Botox | N Y |

**Vascular/ Cardiovascular**

| | |
|---|---|
| Heart Disease | N Y |
| Hypertension | N Y |
| Stroke | N Y |
| Vascular disease | N Y |
| High Cholesterol | N Y |

**Genitourinary**

| | |
|---|---|
| STD/Viral Herpetic/Chlamydia | N Y |
| HIV | N Y |
| Hepatitis | N Y |
| Gonorrhea | N Y |
| Syphilis | N Y |

**Respiratory**

**Smoking status:** Never/ Former/ Daily/ Occasional

| | |
|---|---|
| Asthma | N Y |
| Chronic Bronchitis | N Y |
| Emphysema | N Y |
| Alcohol Abuse | N Y |
| Illegal drug Use | N Y |
| Cancer: | |

**Family History** – Has anyone in the patient's family (blood relative) had any of the following? Please circle No or Yes.

| | | | | | | |
|---|---|---|---|---|---|---|
| Glaucoma | N Y | Cornea Disease | N Y | Hypertension | N Y | **Other:** |
| Cataracts | N Y | Crossed Eyes | N Y | Diabetes | N Y | |
| Macular Degeneration | N Y | Retina Disease | N Y | Cancer | N Y | |
| Lazy Eye | N Y | Blindness | N Y | Heart Disease | N Y | |

***The information provided is true and complete to the best of my knowledge.***

*Patient Signature (or Guardian if patient is a minor)* _____ Date _____

*Name of Person Completing Form (if not patient)* _____ Relationship to Patient _____

***Provider: Keep original signed form in patient's file***

Review date _____ ☐ Changes ☐ No Changes Provider signature _____